PRACTITIONER OF RESPIRATORY CARE
APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS
FOR THE BIENNIAL REGISTRATION PERIOD 2013- 2015
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, NV 89502

Date Received by Board

License No._____

File No._____
(For Board Use Only)

I hereby apply for reinstatement of biennial registration and enclose the appropriate fee as indicated below:

_____REINSTATEMENT FEE $400.00

You may pay by check, cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

Name: _____

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE:

NAC 630.530 (6) Renewal of license; notification of withdrawal of certification; expiration and reinstatement of license.
(6) If a licensee fails to pay the fee for biennial registration after it becomes due, or fails to submit proof that the licensee completed the number of contact hours of continuing education required by susbsections 2 and 3, his license to practice respiratory therapy in this State is automatically expired. Within 2 years after the date his license is expired, the holder may be reinstated to practice respiratory care if he:
(a) pays twice the amount of the current fee for biennial registration to the Secretary-Treasurer of the Board;
(b) Submits proof that he or she completed the number of contact hours of continuing education required by subsections 2 and 3; and
(c) Is found to be in good standing and qualified pursuant to the provisions of NRS 630.277 and this chapter.

- YOUR LICENSE WILL NOT BE REINSTATED UNTIL THE BOARD RECEIVES YOUR ORIGINAL SIGNED *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM. **A FAXED COPY IS NOT ACCEPTABLE.**
- YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM.
- YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."
- ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM IS PUBLIC INFORMATION.

PLEASE TYPE OR PRINT LEGIBLY
PLEASE PROVIDE ALL INFORMATION AS REQUESTED

1. Your application for Reinstatement of Registration of License requires the submission of **proof of current certification by the National Board for Respiratory Care AND proof of continuing professional education (CE) required for this reinstatement cycle only** and as described in NAC 630.530(3) **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CE with your completed ***APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION*** form. (See last page of this form for CE statement.)

2. If your name and/or address have changed, clearly indicate the change in the space provided below. Please be advised, the address you indicate below is viewable on the NSBME website and is listed as the "public" address. Also, please indicate your current public telephone and fax numbers. [Please note: if your name has changed, a copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name_____

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

Email address_____

Indicate below your primary and secondary scope of practice specialties using the following codes:

SCOPE OF PRACTICE SPECIALTY CODES

1 GENERAL FLOOR CARE
2 EMERGENCY / CRITICAL CARE / TRAUMA
3 SLEEP DISORDERS
4 PULMONARY FUNCTION TESTING
5 MANAGEMENT
6 PULMONARY REHABILIATION / CARDIAC REHABILITATION
7 PERINATAL / PEDIATRIC
8 HOME CARE
9 HOME MEDICAL EQUIPMENT
10 FLIGHT MEDICINE

Code **Code**

Primary Specialty ___________ **Secondary Specialty** ___________

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All of the following questions refer to the preceding 24-month time period of the date of your submission of this form or since your last renewal.

For the purposes of the following questions, these phrases or words have these meanings:

"Medical condition" includes physiological, mental or psychological condition or disorders.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REINSTATEMENT* FORM.

1. Do you currently have a medical condition that in any way impairs or limits your ability to provide respiratory care services with reasonable skill and safety?

______Yes ______No

2. If you currently have a medical condition which in any way impairs or limits your ability to provide respiratory care services, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation?

______Yes ______No ______N/A

3. If you currently use chemical substances, does your use in any way impair or limit your ability to provide respiratory care services with reasonable skill and safety?

______Yes ______No ______N/A

4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?

______Yes ______No

5. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?

______Yes ______No

6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you **MUST disclose ANY** investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.)

______Yes ______No

7. Have you been denied a license or certification/registration to provide respiratory care services or permission to practice as a respiratory care therapist or permission to take an examination to practice as a respiratory care therapist or permission to practice any other healing art in any state, country or U.S. territory? _____Yes _____No

8. Have you had a certificate or license to provide respiratory care services or any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____Yes _____No

9. Have you voluntarily surrendered a license or certificate to provide respiratory care services or any other healing art in any state, country or U.S. territory? _____Yes _____No

10. Have you failed the National Board of Respiratory Care examination, or any state or other jurisdiction examination for certification, licensure or registration as a practitioner of respiratory care? _____Yes _____No

11. Have you had your registration/certification revoked, suspended and/or limited by the National Board of Respiratory Care? _____Yes _____No

12. Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a provider of respiratory care by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? _____Yes _____No

OTHER STATES OF CURRENT OR PREVIOUS LICENSURE

List any and all licenses you hold or have held to practice medicine in any state, territory.

State/Territory	License #	Date of Issuance	Dates of Practice

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. _____Yes _____No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

MILITARY ATTESTATION

Have you ever served in the United States Military (to include National Guard or Reserves)? _____Yes _____No
If your answer is "No", you do not have to complete the remaining questions for the Military Attestation.

If yes, in which branch of service did you serve?
- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corp
- ☐ Coast Guard

Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

Dates of service in the Military: **From:** _____/ _____/ _____ **To:** _____/ _____/ _____
DD MM YYYY DD MM YYYY

BUSINESS LICENSE ATTESTATION

Do you hold a Nevada state business license issued in your individual name? _____Yes _____No

If yes, provide the business license number: _____.

NBRC CERTIFICATION ATTESTATION

I am currently certified by the National Board for Respiratory Care. _____Yes _____No

- **ATTACH COPY OF PROOF OF YOUR CURRENT CERTIFICATION.**

(YOUR COPY OF PROOF OF CURRENT CERTIFICATION WILL NOT BE RETURNED TO YOU.)

CONTINUING PROFESSIONAL EDUCATION (CE) STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I was initially licensed in Nevada prior to or during the time period July 1, 2011 through December 31, 2011 and completed a minimum of twenty (20) contact hours of continuing professional education (CE), twelve (12) of which must be directly related to Respiratory Care and two (2) hours must be in the subject matter of ethics or pain management and/or addiction care;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2012 through June 30, 2012, the second six months of the past biennial period, and completed a minimum of fifteen (15) contact hours of continuing professional education (CE), nine (9) of which must be directly related to Respiratory Care and two (2) hours must be in the subject matter of ethics or pain management and/or addiction care;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2012 through December 31, 2012, the third six months of the past biennial period, and completed a minimum of ten (10) contact hours of continuing professional education (CE), six (6) of which must be directly related to Respiratory Care and two (2) hours must be in the subject matter of ethics or pain management and/or addiction care;

_____ (d) I was initially licensed in Nevada during the last four months of the biennial period of registration January 1, 2013 through June 30, 2013, the last four months of the past biennial period, and completed a minimum of five (5) contact hours of continuing professional education (CE), three (3) of which must be directly related to Respiratory Care and two (2) hours must be in the subject matter of ethics or pain management and/or addiction care;

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING PROFESSIONAL EDUCATION (CE) HOURS.** - ***YOUR COPIES OF PROOF OF CE COMPLETION WILL NOT BE RETURNED TO YOU.***

FOR A CURRENT LIST OF APPROVED CONTINUING PROFESSIONAL EDUCATION SOURCES, YOU MAY VISIT THE BOARD'S WEBSITE: www.medboard.nv.gov AND CLICK ON "CONTINUING EDUCATION REQUIREMENTS FOR PRACTITIONERS OF RESPIRATORY CARE.

HOME ADDRESS & PHONE NUMBER ***(REQUIRED)***

Street_____

City_____ County_____ State_____ Zip_____

Phone Number_____ Fax Number_____

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION* OF LICENSE TO PROVIDE RESPIRATORY CARE SERVICES IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;

2) I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION OF LICENSE* WILL BE REJECTED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND

3) I UNDERSTAND THAT THIS *APPLICATION FOR REINSTATEMENT OF REGISTRATION OF LICENSE* WILL BE REJECTED AS INCOMPLETE IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING EDUCATION (CE); (b) THE APPROPRIATE PROOF OF CURRENT CERTIFICATION BY THE NATIONAL BOARD FOR RESPIRATORY CARE; (c) PAYMENT OF THE APPROPRIATE FEE(S); AND (d) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).

_____ _____

Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:
Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510-7238
or fax to:
775-688-2321

***Please type or print legibly*.**

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

_____

_____

_____

Phone Number: _____

Credit Card Number: _____

Expiration Date: _____ / _____
(MM) (YYYY)

For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of $ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____